Westside Dermatology Clinic, PA
1331 W Grand Parkway N #370
Katy, Texas 77493

Date_____ DOB_____ Age___ Sex_____ SS#_____

Patient Name_____ Home phone ( ) _____
Work phone ( ) _____
Address_____ Cell phone ( ) _____

City_____St_____Zip_____ Employer_____Referring Dr._____
Married Single Divorced Widowed

INSURANCE INFORMATION

Primary Insurance_____ ID or Policy number_____

Group_____ Name of Insured_____ Insured DOB_____

Insured Employer_____ Insured SS#_____

SECONDARY INSURANCE _____
ID_____ Group_____
Name of Insured_____ DOB_____

Attention: Attention Attention Please read in full

If your insurance requires a referral for you to see Dr. Paul Subrt, it is your responsibility to provide our office with a valid referral. If your insurance company denies payment due to no referral – You the patient agree, to Pay Westside Dermatology Clinic, PA in full for any charges incurred.

Most insurance plans now consider the co-pay for the office visit only. Procedures, freezing, biopsy & mole removal is considered office surgery and applied to your deductible, which you will be responsible for. I also agree to pay for any charges that are considered cosmetic (lipoma) if my insurance denies the claim.

SIGNATURE OF PATIENT/GUARDIAN/RESPONSIBLE PARTY_____

Notice of Privacy Practice

Dr Subrt and I agree that my medical records are private documents that we both jointly own. A notice of Privacy Practices, which contains more information related to this subject, is available for my review.

Please Choose one of the below and sign on the bottom line.

I ALLOW release of test result or billing to my family_____

I DO NOT allow release of my results or billing to my family_____

Signature of Patient/Guardian/ Responsible Party_____ Date_____